Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

HOUSTON ORTHOPEDIC SURGICAL HOSPITAL
5420 WEST LOOP SOUTH STE 3600
BELLAIRE TX 77401

Respondent Name
INDEMNITY INSURANCE CO OF NORTH AMERICA

Carrier's Austin Representative Box
#15

MFDR Tracking Number
M4-12-2436-01

MFDR Date Received
MARCH 23, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: A position summary was not submitted by the requestor.

Amount in Dispute: $11,870.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The carrier challenges whether the charges are consistent with applicable fee guidelines…The provider is disputing the implant allowance, revenue code 278….In other words, they cannot bill as an implant, bone marrow that came from the patient's own body. Only synthetic material or marrow obtained from a cadaver, ect. would be reimbursable. The kits used to extract the BMA or any other tools used during the procedure that are not going to be in the patient's body permanently or for an extended period of time would be considered supplies and therefore included in the DRG allowance."

Response Submitted by: Flahive, Ogden & Latson, P. O. Drawer 201320, Austin, TX 78720

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 18, 2011 Through July 19, 2011	Inpatient Hospital Surgical Services	$11,870.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.404 sets out the guidelines for reimbursement of hospital facility fees for inpatient services.
3. 28 Texas Administrative Code §133.240 sets out the guidelines for medical payments and denials.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated August 17, 2011

- 150- Payer deems the information submitted does not support this level of service (850-214) CV:THIS CHARGE IS NORMALLY NOT BILLED SEPERATELY
- 16- Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not and ALERT.) (880-016) CHARGE DENIED DUE TO LACK OF SUFFICIENT DOCUMENTATION AND/OR APPROPRIATE DOCUMENTATION OF SERVICES RENDERED $0.00
- 216 — Based on the findings of a review organization (900-030) CV: THIS CHARGE WAS REVIEWED THROUGH THE CLINICAL VALIDATION PROGRAM
- W1- Workers' compensation jurisdictional fee schedule adjustment. (080) REVIEW OF THIS BILL HAS RESULTED IN AN ADJUSTED REIMBURSEMENT OF $520.63 (649-002) REIMBURSEMENT HAS BEEN CALCULATED BASED ON A DRG ALLOWANCE.

Explanation of benefits dated December 20, 2011

- 150- Payer deems the information submitted does not support this level of service (850-214) CV:THIS CHARGE IS NORMALLY NOT BILLED SEPERATELY (900-067) CV: RECONSIDERATION OF THIS SERVICE/PROCEDURE/SUPPLY CODE AND SUBMITTED DOCUMENTATION HAS RESULTED IN ADDITIONAL REIMBURSEMENT. RECOMMENDED FINAL ALLOWANCE (900-068) CV: ADDITIONAL RECONSIDERATION OF THIS BILL AND SUBMITTED DOCUMENTATION DOES NOT SUPPORT ADDITIONAL PAYMENT. RECOMMENDED FINAL ALLOWANCE
- 216 — Based on the findings of a review organization (900-030) CV: THIS CHARGE WAS REVIEWED THROUGH THE CLINICAL VALIDATION PROGRAM
- W1- Workers' compensation jurisdictional fee schedule adjustment. (080) REVIEW OF THIS BILL HAS RESULTED IN AN ADJUSTED REIMBURSEMENT OF $520.63 (649-006) REIMBURSEMENT HAS BEEN CALCULATED BASED ON A DRG ALLOWANCE WITH A SEPARATE ALLOWANCE FOR IMPLANTABLES (670-007) REIMBURSEMENT IS BASED ON THE PROVIDER'S REQUEST FOR SEPARATE PAYMENT CONSIDERATION FOR IMPLANTABLE DEVICES.

Explanation of benefits dated January 10, 2012

- 150- Payer deems the information submitted does not support this level of service (850-214) CV:THIS CHARGE IS NORMALLY NOT BILLED SEPERATELY (900-068) CV: ADDITIONAL RECONSIDERATION OF THIS BILL AND SUBMITTED DOCUMENTATION DOES NOT SUPPORT ADDITIONAL PAYMENT. RECOMMENDED FINAL ALLOWANCE
- 216 — Based on the findings of a review organization (900-030) CV: THIS CHARGE WAS REVIEWED THROUGH THE CLINICAL VALIDATION PROGRAM
  W1- Workers' compensation jurisdictional fee schedule adjustment. (080) REVIEW OF THIS BILL HAS RESULTED IN AN ADJUSTED REIMBURSEMENT OF $520.63 (649-006) REIMBURSEMENT HAS BEEN CALCULATED BASED ON A DRG ALLOWANCE WITH A SEPARATE ALLOWANCE FOR IMPLANTABLES (670-007) REIMBURSEMENT IS BASED ON THE PROVIDER'S REQUEST FOR SEPARATE PAYMENT CONSIDERATION FOR IMPLANTABLE DEVICES.

Issues

1. Were the disputed services subject to a specific fee schedule set in a contract between the parties that complies with the requirements of Labor Code §413.011?
2. Which reimbursement calculation applies to the services in dispute?
3. Is the bone marrow aspirate considered an implantable per Texas Administrative Code §134.404(b)(2)? Are the devices used to obtain the bone marrow aspirate considered implantables per Texas Administrative Code §134.404(b)(2)?
4. What is the maximum allowable reimbursement for the services in dispute?
5. Is the requestor entitled to additional reimbursement for the disputed services?

Findings

1. 28 Texas Administrative Code §134.404(e) states that: "Except as provided in subsection (h) of this section, regardless of billed amount, reimbursement shall be:
   (1) the amount for the service that is included in a specific fee schedule set in a contract that complies with the requirements of Labor Code §413.011; or
   (2) if no contracted fee schedule exists that complies with Labor Code §413.011, the maximum allowable reimbursement (MAR) amount under subsection (f) of this section, including any applicable outlier payment amounts and reimbursement for implantables."

   No documentation was found to support the existence of a contractual agreement between the parties to this dispute; therefore the MAR can be established under §134.404(f).

2. §134.404(f) states that "The reimbursement calculation used for establishing the MAR shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Inpatient Prospective Payment System (IPPS) reimbursement formula and factors as published annually in the Federal Register. The following minimal modifications shall be applied.
   (1) The sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by:
      (A) 143 percent; unless
      (B) a facility or surgical implant provider requests separate reimbursement in accordance with subsection (g) of this section, in which case the facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 108 percent."

   Review of the documentation finds that that the facility requested separate reimbursement for implantables; for that reason, the requirements of subsection (g) apply.

3. Per the respondent's position statement "Bone marrow aspirate (BMA) is used as an autograft, not an allograft, and is not normally billed separately. BMA is from the patient's own body, not from another source. Invoices submitted are for kits used for obtaining the BMA not for a separate cervical allograft. Kits would be included as supplies in the DRG allowance…they cannot bill as an implant, bone marrow that came from the patient's own body….The kits used to extract the BMA or any other tools used during the procedure that are not going to be in the patient's body permanently or for an extended period of time would be considered supplies, and therefore included in the DRG allowance."
   Per Texas Administrative Code §134.404(b)(2) "Implantable" means an object or device that is surgically: (A) implanted, (B) embedded, (C) inserted, (D) or otherwise applied, and (E) related equipment necessary to operate, program and recharge the implantable. Review of the operative report submitted by the requestor finds that the bone marrow aspirate does not meet the definition of an implantable per TAC §134.404(b)(2).
   The requestor has submitted invoices for "Cervical Graft Kit" for $1,356 and "Spine Smith Graft Delivery Kit" for $396 and requested separate reimbursement under TAC §134.404(g). These items were used by the requestor to obtain the bone marrow aspirate. Because the bone marrow aspirate is not considered an implantable, the "Cervical Graft Kit" and "Spine Smith Graft Delivery Kit" used to obtain the bone marrow aspirate would not be reimbursable under TAC §134.404(g) as they do not meet the definition of implantable per §134.404(b)(2)(E).

4. §134.404(g) states, in pertinent part, that "(g) Implantables, when billed separately by the facility or a surgical implant provider in accordance with subsection (f)(1)(B) of this section, shall be reimbursed at the lesser of the manufacturer's invoice amount or the net amount (exclusive of rebates and discounts) plus 10 percent or $1,000 per billed item add-on, whichever is less, but not to exceed $2,000 in add-on's per admission.
   (1) A facility or surgical implant provider billing separately for an implantable shall include with the billing a certification that the amount billed represents the actual costs (net amount, exclusive of rebates and discounts) for the implantable. The certification shall include the following sentence: "I hereby certify under penalty of law that the following is the true and correct actual cost to the best of my knowledge."

   Review of the documentation found supports that the following items were certified as required by (g):

Itemized Statement Rev Code or Charge Code	Itemized Statement Description	Cost Invoice Description	# Units & Cost Per Unit	Cost Invoice Amount	***Per item*** Add-on (cost +10% or $1,000 whichever is less).
278	TH 3.5MM POLYAX SCRW	POLYAXIAL SCREW 3.5 X 12MM	2 at $856.80 ea	$1,713.60	$171.36
278	TH 3.5MM POLYAX SCRW	POLYAXIAL SCREW 3.5 X 14MM	2 at $856.80 ea	$1,713.60	$171.36
278	THE 2.5MM ROD 80-240	ROD 3.5MM	2 at $227.80 ea	$455.60	$45.56
278	THE LKG SCREW	LOCKING SCREW ASSEMBLY	4 at $163.20 ea	$652.80	$65.28

	ASSEMB				

$4,535.60	$4,989.16
Total Supported Cost	**Sum of Per-Item Add-on**

The division finds that the facility supported separate reimbursement for these implantables, and that the cost invoices were certified as required. Therefore, the MAR is calculated according to §134.404(f)(1)(B).

5. §134.404(f)(1)(B) establishes MAR by multiplying the most recently adopted and effective Medicare Inpatient Prospective Payment System (IPPS) reimbursement formula and factors (including outliers) by 108%, ***plus*** reimbursement for items appropriately certified under §134.404(g). The Medicare IPPS payment rates are found at http://www.cms.gov, and the sum of the per-item add-on for which separate reimbursement was requested are taken from the table above.

   - Documentation found supports that the DRG assigned to the services in dispute is DRG 473, and that the services were provided at Houston Orthopedic Surgical Hospital. Consideration of the DRG, location of the services, and bill-specific information results in a total Medicare facility specific allowable amount of $11,526.10. This amount multiplied by 108% results in an allowable of $12,448.19.
   - The total cost for implantables from the table above is $4,535.60. The sum of the per-billed-item add-ons does not exceed the $2000 allowed by rule; for that reason, total allowable amount for implantables is $4535.60 plus 10% ($453.56), which equals $4,989.16.

   Therefore, the total allowable reimbursement for the services in dispute is $12,448.19 plus $4,989.16, which equals $17,437.35. The respondent issued payment in the amount of $17,957.97. Based upon the documentation submitted, no additional reimbursement is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Greg Arendt Medical Fee Dispute Resolution Officer	March 21, 2013 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.